WHITESTOWN

INDIANA

TOWN OF WHITESTOWN
ADA DISCRIMINATION GRIEVANCE FORM

Grievant Information

Grievant Name:			
Address:	City:	State:	ZIP Code:
Phone:	E-mail:		
Alternative Phone:			

Person Preparing Complaint Relationship to Grievant (If Different from Grievant)

Name:			
Address:	City:	State:	ZIP Code:
Phone:	E-mail:		
Alternative Phone:			

Please specify any location(s) and date(s) related to the complaint or grievance (if applicable):

Please provide a complete description of the specific complaint of grievance:

Please state what you believe should be done to resolve the complaint or grievance:

Please provide any additional information you feel is relevant:

Please attach any additional pages as needed:

Signature:_____

Date: _____

Please return to: **Whitestown Municipal Complex, 6210 S 700 E, Whitestown, IN 46075**

Upon request, reasonable accommodation will be provided in completing this form or copies of the form will be provided in alternative formats. Contact the ADA coordinator at the address listed above or via telephone at 317-769-6557.